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July 26, 2010

COPY

Ms. Tracey Sessions
State Hospital South
700 East Alice Street
Blackfoot, ID 83221

Provider #134010

Dear Ms. Sessions:

On **July 2, 2010**, a complaint survey was conducted at State Hospital South. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004623

Allegation #1: Patients' privileges for off-unit activities were restricted in an arbitrary and capricious manner.

Findings #1: An unannounced visit was made to the hospital on 6/30/10-7/02/10. Ten medical records were reviewed. Five patients were interviewed. Staff were interviewed hospital policies were reviewed. Staff was observed interacting with patients.

All medical records contained documentation of treatment team meetings. Privilege levels were decided by the treatment team. These decisions included items such as whether patients were allowed off unit for meals and how often staff observed patients. These decisions were made by the treatment team. They appeared to be made based on the need to keep patients safe and secure.

Medical records documented few restrictions on patients' privileges. Those that had restrictions had documented behaviors which justified the restrictions.

No evidence was found to indicate these decisions were made arbitrarily.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A patient was started on citalopram, an antidepressant, even though he reported that medication was ineffective. The patient instead requested escitalopram oxalate, another antidepressant, but was told this medication was too expensive.

Findings #2: Medical records documented medications were delivered as ordered. One medical record documented a 26 year old male who was admitted on 4/26/10 and discharged on 5/13/10. A progress note by the nurse practitioner, on 5/03/10 at 5:54 PM, stated the patient requested escitalopram oxalate. This was ordered at the same time and was administered to the patient beginning on 5/04/10. No instances were found where a patient requested a medication and did not receive it.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Nursing staff were hostile and intimidating to patients.

Findings #3: Staff was observed interacting with patients on 2 hospital units. Staff was courteous and respectful.

Five of five patients who were interviewed stated staff was respectful and caring. No instances of staff being hostile or intimidating were reported.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Treatment groups were religiously oriented. Also, Christianity was the only religion supported by the hospital.

Findings #4: A review of the treatment calendar did not reveal any groups that were overtly religious.

Five patients were interviewed. All patients stated treatment groups were not focused on religion. They all stated particular religions were not emphasized. The patients stated 2 religious services were available at the hospital on Sundays, a non-denominational service and a Church of Jesus Christ of Latter Day Saints service. Patients stated attendance was solely at the discretion of individual patients. Staff stated these groups were offered by local religious organizations.

The Patient Advocate said Blackfoot, Idaho was a small town and lacked resources to provide information on all religions. She stated one patient, a 26 year old male, had requested information related to a Jewish sect. The Patient Advocate said staff had arranged for this patient to contact a Rabbi in another Idaho town by telephone. She said the patient had in fact talked with the Rabbi while he was a patient.

Religion was neither encouraged nor discouraged at the hospital. Efforts were made to provide religious resources to patients who requested them. Neither state nor federal regulations address the provision of religious resources to patients.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients were not allowed to send and receive letters.

Findings #5: Five patients and the Patient Advocate were interviewed. All of these parties stated patients were allowed to send and receive mail. All of the patients who were interviewed stated they were not aware of any restrictions on mail service.

The Patient Advocate stated one male patient had requested staff pass notes between him and a female patient on another unit. She stated staff refused to pass the notes back and forth. She said the two patients ate lunch together daily and had the opportunity to speak with each other or to pass notes at that time. This was confirmed by interview with the Unit Manager.

Patients' ability to send and receive mail was not restricted.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: Staff sit and watch television or surf the internet instead of interacting with patients.

Findings #6: Two patient units were observed at various times between 10:00 AM and 3:45 PM on July 1, 2010. Neither staff nor patients were observed to watch television or surf the internet or text during that time.

Five patients were interviewed. All patients stated nursing staff and psychiatric technicians were available and attentive to patients. The patients stated staff were caring and respectful.

The Patient Advocate was interviewed. She stated the hospital had investigated the above allegation. She stated the allegation had not been substantiated but the Administrator had sent a memo to all staff warning them against non-work related activities while they were on duty. This was confirmed by interview with the Administrator and unit staff.

No instances were found where staff did not respond appropriately to patients' needs.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Recreational and other staff make fun of patients abilities during recreational activities.

Findings #7: Five patients were interviewed. All patients stated recreational and nursing staff was respectful and caring. All patients denied knowledge of incidents where staff had belittled patients.

No incidents of staff making fun of patients were found.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation#8: Physicians were not available to meet patients' needs.

Findings #8: The hospital employed 3 psychiatrists and 1 physician assistant who worked with the psychiatrists. These practitioners managed the psychiatric care of patients. Physicians completed all psychiatric evaluations. Practitioners met with treatment team members daily to discuss patients and saw patients as needed. Physicians met with patients a minimum of once per week.

Practitioners managed patients' medications, consultations, and overall care. They did not provide counseling services to patients. These services were provided by clinicians and other staff.

Five patients were interviewed. All patients stated there were sufficient staff to counsel patients. All patients stated physicians were available if patients needed to speak to them.

Physicians were available to meet patients' needs.

Conclusion: Unsubstantiated: Lack of sufficient evidence

Allegation #9: Patients were not permitted to hold hands.

Findings #9: The document "RULES FOR DAILY LIVING," not dated, was provided to all patients on admission as part of a larger admission packet. The document stated "Ask before you touch or hug someone. Never touch someone in a sexual way."

The Patient Advocate and a Clinician were interviewed separately. Both stated romantic relationships were discouraged and displays of affection, including holding hands, were not allowed. Both admitted the rules were not specific. Both stated

rules discouraging touching were implemented to keep patients safe. The Patient Advocate stated the majority of patients at the hospital were court committed and, by definition, were vulnerable persons. She stated patients were often susceptible to manipulation by others.

Patient safety is the overriding concern in psychiatric treatment facilities. Therapeutic interactions cannot occur unless patients are free from abuse and manipulation. Hospitals are allowed to place restrictions on patients to keep them safe.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srp